

**CorpOHS Frederick**

490-L Prospect Blvd

Frederick, MD 21701

Phone: 240-566-3001 Fax: 240-566-3003

**Request to Receive Medical Records**

SS#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I, \_\_\_\_\_ (your name) \_\_\_\_\_ (your telephone number) hereby authorize \_\_\_\_\_ to release the medical records of \_\_\_\_\_

\_\_\_\_\_ to the entity named above. This may include information about serious (patient's name) communicable diseases and/or infections as defined by Maryland statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any; alcohol and/or drug abuse information protected under the regulations of 42 CFR Part 2, if any; psychiatric/psychological records, if any; social work records, if any; including communications made by me to a social worker, psychiatrist, or psychologist.

Birthdate of Patient	Social Security Number
Mail to Attention	Phone No. Fax No.
Date(s) Treated	Name Used at Time of Treatment

**RECORDS TO BE RELEASED**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anesthesia Records<br><input type="checkbox"/> Cardiology Reports<br><input type="checkbox"/> Consultation Report<br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> ER Record<br><input type="checkbox"/> Face Sheet<br><input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports<br><input type="checkbox"/> Medication/IV Records<br><input type="checkbox"/> Operative Report<br><input type="checkbox"/> Pathology Report<br><input type="checkbox"/> Physical Therapy Notes<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Radiology Reports<br><input type="checkbox"/> Xray Films<br><br><input type="checkbox"/> Complete Medical Record<br><input type="checkbox"/> Other (specify) _____ |
|--|--|---|

**PURPOSE OF DISCLOSURE**

- |   |   |
|---|---|
| <input type="checkbox"/> Continuation of Care<br><input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Physician's Name: _____<br><input type="checkbox"/> Insurance/Billing Verification Company Name: _____ |
|---|---|

**This authorization must be signed subsequent to the service date you are requesting and may be revoked at any time by notifying the provider in writing, except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will terminate one (1) year from the date of signing. A photocopy or electrostatic copy will have the same authority as the original. Any redisclosure of medical information by the recipient(s) is strictly prohibited. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**

Signature <b>X</b>	Date	Signature of Witness <b>X</b>	Date
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I.D. Check  
Relationship to Patient \_\_\_\_\_  
**(Note: If patient is unable to sign, the legal guardian or personal representative may sign. Proper court papers must be presented.)**

**FOR PATIENTS REQUESTING XRAY FILMS**

Xray films are the property of the service provider and requesting physicians are not authorized to keep them. If lost, original films cannot be replaced. When taking original films, patient acknowledges their responsibility to return the films within a reasonable period of time after completion of their appointment. Upon written request, original mammogram films may be permanently transferred.